

THE RELATIONSHIP BETWEEN SPANISH PROFICIENCY AMONG HEALTH CARE PROVIDERS AND HISPANIC'S  
PERCEPTION OF QUALITY OF CARE AT PUBLIC HEALTH CLINICS

BY

RUNNELL TOWNSEND JR.

THESIS

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Adviser:

Professor Reginald Alston

## **ABSTRACT**

The purpose of this study is to determine whether there is a relationship between the mastery of Spanish by health care providers in free clinics and the perceived quality of care by Spanish speaking immigrants. Although there are many reports about physician-patient communication, there are few qualitative reports in the state of Illinois that address this issue as it pertains to the Hispanic population. Interviews were administered among Hispanic patients' ages 18-64 years. Surveys were administered within a two week time frame at Champaign Urbana Public Health District, a local public health center. The results showed that providers lack the initiative to provide interpreters on a frequent basis and this impacts the patient's perceived quality of care. Education level is a factor that influences the patient's ability to rate the quality of care they receive. It seems as though most of the population between the age group of 20-29 years of age are uninsured.

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## CHAPTER 1: INTRODUCTION

### Significance

This study is significant as it relates to the Health care industry because physician-patient communication is essential in measuring quality of care. Cultural competence is merely the understanding of the differences between the many ethnic groups around the world (Betancourt, Green, Carrillo, and Ananeh-Firempong II, 2003). There are many different things that make up a person's cultural identity including: country of origin, language, education, spiritual traditions, family traditions, diet & nutrition, traditional medical practices, attitudes about death, and migration experiences to name a few ("Champlain Valley Area Health Education Center," 2007).

From a national perspective, the health status of the United States of America is fairly poor in comparison to other rich countries. In the last decade, the annual improvement of America's health has declined 69% in comparison to the 1990s ("United Health Foundation," 2011). According to the United States Census Bureau:

"The Hispanic population is growing tremendously and has become the largest minority group and still increasing. With this ethnic group being one of the largest and experiencing barriers prohibiting consistent health care, the Hispanic population health status affects a large part for the entire nation." (Guzman, 2001, p. 2).

One of the major influences to Hispanics perceived quality of care is due to a language barrier. Williams, Davis, Parker, and Weiss (2002) as cited in The Qualitative Health Research Journal (2008) found [Further, relative to the size of the Hispanic population, physicians in new growth communities experienced more language barriers and problems communicating with patients compared to physicians in the major Hispanic populated areas.] The Qualitative Health Research Journal (2008) found that Hispanics with low English proficiency or non-English

speakers are more likely to have worse health status when compared to English-speaking Hispanics (Kirkman-Liff & Mondragon, 1991, p. 635)

The purpose of this study is to examine the importance of language proficiency among employees in the health care setting and its influence on the perception of quality from Hispanic patients.

### **Why is it important nationally**

From a national perspective, language proficiency among employees in the healthcare setting and its' influence on the perception of quality from Hispanic patients is important because the Hispanic population is exponentially growing. There is a clear and distinct difference in perceived quality as it pertains to ethnicity and language. In the National Survey of American Families (NSAF), as in most other surveys, Hispanics reported poorer health status than non-Hispanics (Ku, and Matani, 2001). It has been speculated that this might be caused by cultural differences in how Hispanics describe their health status, as compared to differences in more clinical or objective measures of health (Leighton, 2001). It is important to the field of Community Health from a national standpoint because this is a primary factor for health disparities among ethnic groups in North America. It is imperative that physicians be aware of how their cultural and economic experiences have influenced their understanding of patients' needs ("Minorities in Medicine," 2005).

As immigrants continue to migrate to the U.S. and the Hispanic population continues to grow, the English language continues to be a barrier for a better quality of care. Of those respondents who have received health care in the past five years, 23 percent report having received poor-quality medical treatment and 23 percent report that their accent or the manner in which they speak English contributed to their poor treatment (Johnson, 2007). It is necessary that

the nation address the perception of low quality of care received by Hispanics in order to modify the curriculum of education in the health care field, or even create some system to eliminate the language barrier that directly affects the quality of care among the Hispanic population.

### **Spanish Speaking Employees in Health Facilities**

Lack of cultural and linguistic compatibility can affect patient satisfaction and outcomes (Brewer, 2008). With the U.S. being so diverse in ethnicity, accommodations to cultural specific needs should be addressed in order to prevent the disparities we experience as a country. If physicians cannot communicate with their patients, this creates an ongoing issue for the entire health system in the country as it relates to population specific needs. Adverse consequences, such as difficulties with informed consent, inadequate understanding of diagnosis and treatments, dissatisfaction with care, and clinician bias, can occur when cultural and linguistic problems exist in the provision of care (Flores, 2002). Though this issue has not been a primary focus, there have been efforts to minimize the inadequate services for certain populations such as Hispanics.

In 2000, the federal Office of Minority Health issued the *National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care*, which addresses three different topics: (1) culturally competent care, (2) language access services, and (3) organizational supports for cultural competence (Perkins, 2003). According to the Policy Brief Journal:

“The three standards related specifically to language access services are mandated for organizations receiving federal funds. These standards address staff recruitment, staff training, access to bilingual staff or interpreters, and notification of all low English

proficiency (LEP) patients regarding their right to free interpretation services.” (Au, Taylor, Gold, 2009).

The Hispanic population struggles to communicate verbally in order to obtain adequate care in the health industry (Kurtz, 2002). LEP affects 40% of the Hispanic population (Kaiser, 2002). With the scarcity of Hispanic patients speaking fluent English, healthcare facilities still lack necessary interpretation services to alleviate this barrier for the Hispanic population (“Champlain Valley Area Health Education Center,” 2007). Only one in five rural hospitals (19.6 percent) reported having interpreters on staff whose primary role is to provide interpretation (Brewer, 2008). Why would an interpreter be relevant to how Hispanic patients rate their quality of care?

### **Rationale for the Study**

As an undergraduate student interning at a prestigious hospital in the Midwest; I was fortunate enough to witness, the disparities that predominantly exist throughout the nation. While interacting with administrators in the emergency room, it was clear that Hispanic patients could barely translate the paperwork they needed to fill out before being seen by a doctor. Once seen by a provider, there were instances where the patient had to communicate through a close family member that speaks little English but did not quite understand what was actually being conveyed from the doctor to the patient. Though many health facilities are required to have interpreters, not all interpreters are available because of patient overflow, or other obligations prior to the patient’s arrival time. Although hospitals in counties with large, stable Hispanic populations indicated seeing more LEP patients, hospitals in counties with rapidly growing Hispanic populations were statistically more likely to report high need for translation services (Brewer, 2008).



As a graduate student, I was enrolled in a course about immigration health and society. Throughout this course, it became apparent that the Hispanic population experiences major issues with America's health-care system. Among Hispanics, disparities exist in access to preventive health care for chronic diseases and conditions, including: cardiovascular disease, cancer, diabetes, mental health, end-stage renal disease, pediatric and maternal care, rehabilitation, and nursing home services (Institute of Medicine, 2003). The most recent annual National Healthcare Disparities Report (NHDR) indicates that although disparities in access to health care diminished for all other minority groups, they increased among Hispanics (Agency for Healthcare Research and Quality [AHRQ], 2005). Disparities exist on a broad scale in relation to the healthcare system. I hypothesize that the lack of language proficiency among the healthcare providers directly influences those disparities within the Hispanic population. The purpose of this study is to examine the interplay between patient-doctor communication and perceptions of care among Hispanic patients. Three theories were used in this study to carefully examine the cognitive process in Hispanic patients and how they perceived the quality of care given to them.

### **Research Question**

What is the relationship between the language proficiency in Spanish by healthcare providers in free health clinics and the perceived quality of care by Spanish speaking patients?

### **Hypothesis**

There is a direct relationship between the healthcare providers in free health clinics and the perceived quality of care by Spanish speaking immigrants. The more proficient a provider is with the Spanish language, the higher the quality of care will be perceived by the Hispanic

patient. The less proficient a provider is with the Spanish language, the lower the quality of care will be perceived by the Hispanic patient.

### **Definitions**

**Language-** A body of words and the systems for their use common to a people who are of the same community or nation, the same geographical area, or the same cultural tradition (“Language,” n.d.).

**Hispanic-** A person of Latin-American or Spanish descent living in the US (Guzman, 2001).

**Barriers-** Anything that restrains or obstructs progress, access, etc. (“Barriers,” n.d.).

**Low English Proficiency-** Limited ability to read, write, speak, or understand English (Cristancho, Garces, Peters, Mueller, 2008).

**Perceived Quality-** Perceived quality can be defined as the customer's perception of the overall quality or superiority of a product or service with respect to its intended purpose, relative to alternatives (Kurtz, 2002).

## **CHAPTER 2: LITERATURE REVIEW**

### **Hispanic Population**

According to the United States' Census Bureau there has been a demographic shift in U.S.; the Hispanic population grew faster than expected *and* accounted for more than half of the nation's growth over the past decade with the groups increased driven by births and immigration. While the Hispanic population continues to grow, they now account for 16% of the Nation's population (Guzman, 2001). Though the Hispanic population is increasing exponentially, they are underrepresented politically and electorally (Guzman, 2001). "Secondly, a large segment of the 'legal' Hispanic population cannot vote because they are not yet citizens of the US...In the November 1988 election, for example, fifty-two percent of all Hispanics legally in the US. did not vote because they were ineligible" (Garcia, 1996). More specifically, low-income Hispanics make up majority of the Hispanic population that are underinsured. The Hispanic population increased by 57.9 percent, from 22.4 million in 1990 to 35.3 million in 2000, in comparison with an increase of 13.2 percent for the total U.S. population. (Guzman, 2001). From the year 2000 up until 2010, the Hispanic population has grown from 30 million to 50 million and will continue to grow and become the majority by 2050 (Cristancho, Garces, Peters, & Mueller 2008). With the Hispanic population accounting for a large portion of the population in the nation, the health care status is affected. These are some of the reasons health disparities exist in the nation and impact the health care system as a whole.

### **Healthcare and Hispanics**

With the Hispanic population growing so fast, it is hard to find employment that pays well and also that provides health benefits. Over one-third, or 39 percent, of Hispanics were

uninsured compared with only 14 percent for non-Hispanic whites (Garcia 2004). Fennelly and Leitner, who conducted research at Julian Semora Research Institute at Michigan University, found that in 2002 “market saturation, low numbers of available jobs, and the often fragile nature of local economic conditions in urban areas are factors that encourage low income Hispanics to seek employment opportunities in suburban and rural areas” (Cristancho, Garces, Peters, and Mueller, 2008).

### **How Government Care is Allocated**

On July 30, 1965, President Lyndon B. Johnson signed a set of laws which pushed the Medicaid program into effect. Funded by both states and federal government Medicaid provides medical assistance to those individuals who are considered to meet the terms of eligibility. Although established to aide those individuals who *can't* afford health insurance, Medicaid is not available to all poor people (Hope, 2005). Although low income is the main qualification for Medicaid, there are other aspects accounted for when determining eligibility. In order to be considered eligible for Medicaid one must fall under a specific group which is defined as qualified for the assistance. Some of these qualifications depend on whether an individual is disabled, pregnant, elderly, and it also depends on the age of the children who are being applied for Medicaid.

Medicaid being the largest source of funding for medical and health-related services for America's poorest people has many successes throughout its history. Medicaid has provided supplemental health coverage for the country's people in need. With America's historical economic struggles, this title of the Social Security Act has contributed to the health status that the United States withstands today (Hope, 2005). This policy has a considerable flexibility within the states' Medicaid plans, however, some federal requirements are mandatory if federal

matching funds are to be received. A state's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations (Cromwell, 1978). These services that contribute to better living conditions for those unable to provide are: inpatient/outpatient hospital services, pregnancy related services, which includes prenatal care, and postpartum care, vaccinations for young children, physician services, nursing facilities for people over twenty-one, family planning and supplies, rural health clinic services, pediatric care, primary care services, and ambulatory care (Kaiser, 2010). Though some of these services are limited on a state by state basis, they have all contributed to better lifestyles and assistance for those that are unable to provide for their family or themselves. In essence, the main objective of Medicaid is to provide access, better quality of care, specific benefits, and enhanced outreach programs for the poor, with emphasis on dependent children and their mothers, the disabled, and the elderly. Under these provisions, not all expectations are met.

Barriers exist among all ethnic groups, specifically minorities, however the Hispanic population is one of the predominant ethnic groups that experience these barriers. Minorities, particularly Hispanics, reported barriers in health-care more frequently than did non-Hispanic whites (Phillips, Mayar, and Aday 2000). For Hispanics living in the United States, barriers such as lack of health insurance, non-eligibility for certain public assistance programs, costs of health care services, language and lack of medical interpretation services, citizenship status, and lack of transportation are all of particular relevance (Cristancho, Garces, Peters, & Mueller, 2008). Because of the claim that health insurance is limited amongst the Hispanic population, they tend to seek services at free health clinics, or local health departments. The National Healthcare Disparities Report (NHDR), states that more than one third of Hispanics under the age of 65 lack health insurance (Cristancho, Garces, Peters, & Mueller, 2008). Carrillo, Trevino, Betancourt,

and Coustasse reported that many low-income Hispanic immigrants are not eligible for governmental health assistance programs or cannot afford to purchase private or employer-sponsored health insurance when available (Cristancho, Garces, Peters, & Mueller 2008).

### **Negative Impact on Hispanics**

The Hispanic population consists of Hispanic Americans, Hispanic Immigrants, and undocumented Hispanic Immigrants. Those that are U.S. citizens, have the same requirements as any other American in the country in order to be eligible for Medicaid (Kaiser, 2006). Immigrants have a few more stipulations that hinder their eligibility. According to Kaiser Family Foundation, there were 35.2 million immigrants in the U.S. in 2004, representing 12 percent of the total population. Nearly 40 percent were naturalized citizens, and just over 60 percent were non-citizens. Of the total foreign-born population, an estimated 30 percent were undocumented (Kaiser, 2006). Since the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996 changed the eligibility requirements for immigrants, it made circumstances more difficult for immigrants to acquire insurance, specifically Medicaid (Ku, and Matani, 2001). In order for an immigrant to obtain full citizenship and thus be eligible for Medicaid, they must have resided in the U.S. for five years or more (Kaiser, 2009). Hispanic families that reside in the U.S., struggle to get over the poverty level due to one individual in the family being provided health benefits (Ku, & Matani, 2001). Immigrants have a disadvantage of acquiring health care due to restricted access of care from living in rural areas, employers only providing insurance for the employee rather than the entire family, and the complications of obtaining citizenship, especially for Hispanic immigrants (Brewer, 2008). Rehm claimed in the Qualitative Research Method Journal in 2003 that “For the limited number of Hispanics who qualify for health assistance programs, it is often difficult to access health care because of the

frustration and confusion caused by the bureaucratic process necessary to enroll in these programs (Cristancho, Garces, Peters, and Mueller, 2008). Strickland, and Wooldridge stated in the Journal of Rural health in 1996 that “In rural areas this becomes even more difficult because of the increasingly smaller pool of providers who will accept Medicaid patients (Cristancho, Garces, Peters, and Mueller, 2008). Though there are many negative influences the healthcare system has on the Hispanic population, there are also some positive impacts.

### **Impact on Hispanics Positively**

The big controversy currently is whether President Barack Obama has intentions on furtively supplying health care for undocumented *and* documented immigrants. Though the reform still prohibits eligibility for undocumented immigrants under any circumstances, they are still allowed to receive care at local free clinics that provide primary care and other preventative services. Both the House and Senate bills prohibit undocumented immigrants from receiving federal subsidies to purchase exchange coverage, *and* continue to bar them from enrolling in Medicaid (Kaiser, 2010). The Senate bill also bars undocumented immigrants from buying coverage through the exchange at full cost with their own funds (Kaiser, 2009). Under the Medicaid reform, there are intentions of constructing more clinics in order to cover for the increased amount of patients that will rapidly multiply in the next few years due to the Medicaid expansion. People with incomes above 133% of the poverty level who do not have access to employer sponsored insurance will obtain coverage through the newly created state health insurance Exchanges (Kaiser, 2010). Some health clinics do not require insurance plans, thus providing care for all. Many Americans are against the idea of providing care for immigrants, but from current research, low-income Hispanics are comprised of most custodial jobs. Yax conducted a survey for the Hispanic Population of the United States Current Population Survey

and found that “For many reasons, including a lack of the education and training necessary to obtain better paying positions in the workforce, Mexican American men and women fill a disproportionate number of these low-paying service jobs” (Flores, and Deal 2003).

Ethnic groups that will benefit the most from the new health reform are Hispanics and African-Americans. Socioeconomically, these two ethnic groups are at the lower end of the ladder, and with the expansion in place, the amount of covered individuals should increase tremendously - creating better health-care for more individuals in the United States. The Health Reform is *very* helpful to low-income Hispanics. “Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level (\$14,404 for an individual and \$29,327 for a family of four in 2009) based on modified adjusted gross income. This expansion will create a uniform minimum Medicaid eligibility threshold across states and will eliminate a limitation of the program that prohibits most adults without dependent children from enrolling in the program today (though as under current law, undocumented immigrants will not be eligible for Medicaid),” (Kaiser, 2010). With the current system undergoing amendments, hopefully disparities will decrease. A number one contributing factor to disparities as it relates to the Hispanic population is communication with healthcare providers.

### **History on Physician-Patient Communication:**

“When I first began working with communication in medicine back in the 1970s, clinical competence included only three items: medical technical knowledge, physical examination, and medical problem solving” (Kurtz, 2002). At one point in health care, it was never a priority to satisfy the natural sentiments of a patient, but rather diagnose, analyze, and cure. To an extent, informing the patient on diagnosis and prognosis was not of importance to the physician because



of the feeling of superiority. “In fact, when some of us suggested in those early years that formal communication education and evaluation become part of the medical school curriculum, the response all too often was some version or another of: ‘AARRGGHH!’” (Kurtz, 2002).

Physicians were reluctant to explain anything simply because they believed that patients would not understand, and the issue would be too complicated to comprehend. Rather than attempting to rationally convey the message in a vivid manner - at that point in history, physicians simply neglected the notion of explanation to their patients. The terminology or “language” that health care providers use *now* to communicate with patients is still a barrier for patients with inadequate health literacy. “Multiple studies document that physicians’ use of medical terms, combined with patients’ limited health vocabulary, results in inadequate and even confusing communication, and patients commonly complain that physicians do not explain their illness or treatment options to them in terms they can understand” (Williams, Davis, Parker, and Weiss, 2002).

Even immediately after leaving their physicians’ offices, patients are able to recall 50% or less of important information just given to them (Williams, Davis, Parker, and Weiss, 2002). Indeed, the concept of poor “health literacy” has been coined to describe patients with an inability to “obtain, process, and understand basic health information and services needed to make appropriate health decisions (Williams, Davis, Parker, and Weiss, 2002). Health care facilities a few decades ago were oblivious to illiterate patients and this fact was reflective in the educational materials given to patients for reference. In most cases, patients are given discharge instructions - helpful information for the patient to get healthy or simple resources for patients regarding potential future illness. Though the intent behind the educational material is to help the patient, the message sought is usually lost due to health illiteracy. “Numerous studies have documented that standard patient education materials are frequently written at levels exceeding

patients' literacy skills. Studies in the mid-1990s found that only 19% of health education pamphlets written for parents of pediatric patients were written below a ninth-grade level, and only 2% were written below a seventh-grade level—placing them beyond the reading comprehension of most US adults, for whom average reading skills are at the eighth-grade level” (Williams, Davis, Parker, and Weiss, 2002). If health information is incomprehensible, how can health care facilities expect quality of care to be sufficient from the patient's perspective? A change was necessary for the healthcare system at that point in time.

### **Evolution of Physician-Patient Communication:**

As health care evolved, so did the new objectives and motives to improve patient care outcomes. Policymakers began to realize the importance of the physician-patient relationship, a major factor that affects the perception of quality on low-income patients. Physicians at one point did not explain adequately, instructions to the people they treated. Although physicians frequently believed they spoke to patients in layman's terms, patients and nurses did not perceive this (Williams, Davis, Ruth, Parker, Wiess, 2002). As time progressed and statistics became more crucial in health care, it became evident that a change in communication and relationship was essential. Today it is rare to find anyone who would not agree that communication is a basic clinical skill and support for formal communication skills training at all levels of medical education has mushroomed (Kurtz, 2002). National organizations began to think systematically on how to improve physician-patient communication to a level of professional competence.

Researchers speak of two factors that have been responsible for the shift in attitude and practice within health care systems with one being the exponential growth of the evidence base regarding communication in medicine, along with the advent of videotapes (Kurtz, 2002). It was

found in the Canadian Journal of Neurological Sciences that collecting data, and recording statistics regarding medical results, have helped to create awareness of neglect, malpractice, and other errors in medicine. Videotapes have allowed health care professionals to see medicine from another perspective and created the ability to critically analyze the system at which is practice in every day care. From these factors, the evolution of physician-patient communication began. In recent years, the necessary actions have been executed in efforts to improve care into what is known as quality care. With these factors being instrumental in creating better quality, other factors are critical in contributing to better quality as well (Kurtz, 2002).

### **Educational Curriculum-Communication:**

In order to provide emphasis on the educational curriculum difference from decades ago until present time, I will use the literature, “Spirit Catches You and You Fall Down,” by Anne Fadiman. With this book written in 1997, it encompasses the practices of physicians that were implemented on patients back in the late twentieth century.

The book “Spirit Catches you and you fall down,” encompasses many issues that exist today in healthcare. The title, being a very catchy one, essentially summarizes the entire book itself in so many words. The Hmong people being the main characters in the book have many beliefs and practices as it relates to health. The title simply is a metaphor for an epileptic disease that results in frequent seizures. To the Hmong people, it was a spirit catching the soul temporarily and taking it away, and then the body falls down and seizes. The main points in this reading are: the different faults within the healthcare system that cause health disparities, language/culture barriers within the health system, and governmental control in the health care.

When the term strict is used, it is used in a sense that American society tends to have a narrow mindset that sensually sets us back as a people.

The first main point is the different faults within the health care system and language/culture/belief barriers that cause health disparities. In relation to the book from the author's experiences with the Hmong people and her research regarding the situation with the Lee family, there were many situations where the Hmong family experienced prejudice emotions from the doctors and resulted in negative outcomes. For instance, the husband and wife Doctors, Neil and his wife worked diligently together to take care of the main character in the book, Lia Lee. These doctors cared for Lia for quite some time until a barrier "prevented" adequate care for the patient her. Lia's parents didn't know any English in order to communicate with the professionals, and on top of that, there weren't any translators available to make the situation better. As the care providers prescribed medications for the baby, the parents were then responsible to issue these medications in a certain dosage at a certain time. In essence, instructions were given to this non-American people and expected to accurately medicate their child.

The language barrier then rose to a peak at this point. The doctors were noticing that the baby had inefficient amounts of medicine they actually prescribed, meaning the parents were not trusting the American doctors and sticking to their culture's rituals and sacrificing animals and to care for their daughter. The doctors then sought it to be a language barrier and later assumed that the parents were deliberately refraining from giving Lia her meds. They then got the government (Child Protective Services) involved because they felt the parents were detrimental to their patient. Doctors then came to the realization that it could have been simply because they didn't understand the prescribed instructions, couldn't read them, or they were just confused because

the medications and dosages were changed so often (24 times in a 12 month span). Then the doctors began to question themselves, and if they didn't change the meds as often *and* were consistent with the best drug, then would that have been more beneficial to Lia's family? A family that can't adhere to the prescribed instructions due to a language barrier? If it had been an American girl with the same condition, she would have been adequately treated because there wouldn't be a language barrier, or a culture belief contradiction.

To conclude the first two main points as they correlate, other ethnic groups experience worse health conditions due to the faults in the health care system and the language/culture barriers that exist.

Lastly, the governmental control concerning the health care system is faulty as well. It seems as though the government only involves themselves with certain issues. As soon as the doctor has suspicion about an issue regarding patients, they are quick to investigate, and though there are clearly culture barriers that differentiate in the belief system Americans have with the Hmong people, they are never willing to negotiate a compromise. This is the case especially if the alternative contradicts or goes against the American practice. Hmong people avoided American hospitals, specifically, Merced Community Medical Center (MCMC) in California simply because their treatment was different from their own, and it seemed that the Christian doctors there, were only trying to convert patients to their own religion rather than treat for the actual medical problem. Along with this, the Hmong people were already said to be stubborn, free-willed, ambitious, strong, and rebellious if it went against what they wanted to do. Their approach to treatment was holism, and they felt that Americans just wanted to study the patient rather than help the problem. Roger Fife was the only doctor the Hmong people requested simply because he talked slow, and didn't cut-off patients; he essentially did what they preferred and

kept their beliefs in mind. I mention this to say that the argument the author is trying to get across is that the American government seems to not be culturally competent and only has involvement depending on the stature of the person or people reporting the existing “problem.”

This book offers many lessons to the health care system. Health and culture relate to one another in so many ways. For example, we can propose predictions about one’s health based on their culture due to common practices within that culture. In essence, health and a people’s cultural beliefs, in tandem, should not be overlooked, but rather processed in order to make fair and critical decisions to uphold our social justice system, *if that even really exists*. All of this falls on the educational system at which the physician learned his practices through and the amount of concern a physician naturally embodies for each and every one of his/her patients.

In reality, students and residents learning patient-communication skills throughout their practice are being put in confrontational predicaments. They are simply learning communication through personal experiences, or observing what their teachers or mentors model. “Learners may observe snippets of patient care, but rarely do they get to observe – much less discuss – the gamut of communication skills involved in setting up relationships with patients for the first time, taking their complete or focused histories, doing explanation and planning, working with patients over time, etc.” (Kurtz 2002). Learners “think” effective communication is having great problem-solving skills. This is not to say that communication skills are independent upon the ability to problem solve, but the notion that no feedback regarding a physician’s communication is provided for the learners after interaction with a patient can prove to be detrimental. When people base their communication skills on personal experiences and personal perception, it can often be distorted and bias.

Today, many physicians have made efforts to focus more on patient-centered care, but the biggest perceptual problem is time. Physicians worry more about the allotted time to actually master the material they encounter in the educational curriculum within their school of medicine than physician-patient communication tactics. Be this as it may, efficiency has to take accuracy, *quality*, and the outcome into account, not just time (Kurtz, 2002). Rather than thinking of communication as an additional topic in school learning, it can be learned simultaneously through practice. “Consider a sports metaphor again. When I was learning to ski I can tell you that it took me 45 minutes to get down a hill that I can now easily ski in three minutes. The hill has not changed. My skill level has” (Kurtz, 2002). “A relevant study compared physicians who engaged in patient-centered practice (which is very similar to relationship-centered care) with those who did not engage in such practice. The latter took 7.8 minutes on average per consultation. Physicians who had mastered the patient-centered skills took 8.5 minutes – less than one minute longer. However, while they were learning the skills, physicians took nearly 11 minutes” (Kurtz, 2002). Focusing more on patients, it is necessary that the language spoken is proficient and comprehensive.

### **Importance of Language Proficiency**

With the United States being so diverse, it is essential that language proficiency in health care be accounted for. Having so many ethnic groups being care for medically, it is essential to be culturally competent and have language services provided. The U.S. Census Bureau (2000) estimates that in the United States, approximately 47 million people speak a language other than English at home (Brewer, 2008). When Healthcare facilities calculate the quality of care perceived by patients, the language factor plays a major role. Lack of cultural and linguistic compatibility can affect patient satisfaction and outcomes (Brewer, 2008). Adverse

consequences, such as difficulties with informed consent, inadequate understanding of diagnosis and treatments, dissatisfaction with care, and clinician bias, can occur when cultural and linguistic problems exist in the provision of care (Brewer, 2008). Specifically for the Hispanic population, language is a barrier that prevents quality of care from their perspective. This can either be from a lack of communication from the provider, or the failure to provide interpretation services. LEP is common among the Hispanic population, 40 percent of whom report speaking little or no English (Kaiser, 2002). Though certain policies require federally funded facilities to provide interpretation services, there are many that don't, and if they do, they are limited.

Federal regulations address the language needs of LEP patients. The linguistically isolated have the right to "reasonable, timely, and appropriate language care" under Title VI of the 1964 Civil Rights Act (Brewer, 2008). Despite the increased risk of communication errors and patient safety risks, many hospitals do not provide interpreter services (Brewer, 2008). Some healthcare facilities would argue that cost is a barrier to providing interpretation services. If a patient receives the wrong discharge instructions due to language, that patient has to be readmitted wasting time/money. If an interpreter were there to communicate appropriately, this wouldn't have been a time sensitive case, and would have been cost effective. The Office of Management and Budget estimates that \$268 million annually, a 0.5 percent increase in the national health care expenditure, would be needed to provide interpreter services in all healthcare encounters (Ku and Flores 2005; Flores and Mendoza, 2002). Language Proficiency is a prime factor that influences patient satisfaction.



## **CHAPTER 3: METHODOLOGY**

### **Research Design**

A qualitative approach was taken in order to thoroughly analyze the data collected in this research. The assessment process was to qualitatively explain the effects of language proficiency among health care providers on Hispanic patients perception of quality care.

### **Procedures**

Patients from the CUPHD had the voluntary option to take a survey that encompassed various questions regarding their satisfaction and what practices the provider's used to achieve that level of satisfaction. Specifically, those patients who spoke limited English were my primary focus. Upon recruiting this population, the clinic allowed me to administer my survey to their patients. The survey specifically asked if the patient was Hispanic and speaks Spanish as a primary language. All surveys that answered "no" to this question were not included in my data analysis. I was physically at CUPHD administering these surveys with the provider in the waiting room and I thoroughly explained my research topic and its implications. I speak moderate Spanish and read the survey in Spanish if needed; CUPHD also provided an interpreter to help translate the survey. I made the patient aware that the survey was absolutely voluntary and that the results would be used for my thesis research in compliance to completing my program at the University of Illinois at Urbana-Champaign. After completion of the survey, I kept record of every survey by maintaining each survey in a brief case in compliance to IRB.

## Participants

To participate in this study, my target population participants had to have been of Hispanic descent, between the ages of 18 to 65, and speak Spanish as a first language.

Confidentiality was maintained during and after data collection. Names of participants were not collected. Any patient that shared experiences was not included in the summary of the data collected. There was also no association link between the people who completed the survey. The experience of the Hispanic patients for this research was the main focus in collecting my data. After compiling all surveys, analysis indicated that 80% of the patients were women and the other 20% were males. In most cases, the mother or father were not those seeking attention, but rather present because they were seeking care for their children. The data collected indicates that women are more likely to take their children to their care provider than men. The surveys collected were answered mostly by women. The data analysis was conducted by using simple math in order to calculate percentages.

More than half of the males and females were of Mexican descent. There were very few nationalities other than Mexican Hispanics but those outside the larger groups included Mexican-Puerto Rican, Columbian, Puerto-Rican, Black and Mexican, Mexican-White, Puerto Rican-White, and Guatemalan. Of 45 Females, 33 were Mexican, of 11 males, 7 were Mexican. All others fall under one of the other categories. In relation to education, of the 45 female patients, 1 had a G.E.D., 3 completed their associates, 6 did not complete any schooling, 15 completed Bachelor degrees, and 20 completed high school. Between the 11 males, 1 had an associates, 3 had a Bachelors, and 7 completed high school.

Age population varied. I divided the age groups from 20-29 years, 30-39 years, and 40 years and up. For the females, 30 of the patients were between the ages of 20-29 years of age, 12 were between 30-39 years of age, and 3 were 40 years and up. In regards to males, 7 were between the ages of 20-29 years of age, and 4 were 30-39 years of age. It seems as though most of the population between the age group of 20-29 years of age are uninsured. The majority of males' highest level of education was high school completion. The fact that a majority of the patients only complete High School may have some relation to why this age group is uninsured and attending free health clinics.

## **Measures**

The survey used in this study was designed to assess patients' perception of quality and their decision making process. The administration of the survey occurred through the facility at Champaign-Urbana Public Health District (CUPHD); I had developed a relationship with a few faculty members at CUPHD through U of I collaborations and was able to conduct research at their facility. During orientation at CUPHD before conducting research, the faculty indicated that patients of Hispanic descent usually set appointments on Tuesdays and Thursday. Four hours at CUPHD were spent collecting data on Monday, Wednesday, and Friday, while 7 hours there on Tuesday and Thursday. Surveys were administered approximately in two week time frame.

There were three dimensions measured during this process of administering the survey, (a) if the provider spoke the same language, would the health care experience be less difficult or confusing and have higher quality, (b) overall quality of care, and (c) if an interpreter was needed to communicate, were they available. The survey is composed of 4 questions that allow the participant to answer yes or no format, or provide a rating of excellent, good, needs

improvement, or poor; one question asked participants of Hispanic/Latino descent the primary language spoken. Each survey identified various demographics that included: gender, education level, origin of decent within the Hispanic ethnic group, and age.

**Gender:** Each participant was marked as male “M” or females “F”.

**Education level:** Each participant was asked what level of education they completed in order to analyze the association of education with the perception of quality of care received.

**Origin of decent:** Each patient was asked their nationality so that I can determine the population group that was seen at CUPHD and how frequent.

**Age:** Each patient was asked their age in order to break down the age population that visited free health clinics in small urban areas.

## **Results/Discussion**

Question 2 asks: If you and your provider spoke the same language, would the health care experience be less difficult or confusing and have higher quality? I divided the males and the females in two different groups; 44 of the 45 female participants answered yes. It is obvious that if language were not an issue in health care settings, quality of care would be greater and information would be less confusing. As for male participants, 10 of 11 answered yes. These data indicate that both genders largely share the same sentiments in regards to the importance of speaking the same language as their healthcare provider.

Question 3 asks: How well would you rate the overall quality of care you receive? Of the 11 males that answered this question 4 indicated “excellent” 5 “good,” and 2 “poor”. Of the 45 females answered this question 8 indicated “excellent,” 18 “good,” 11 “needs improvement,” and

8 “poor”. For this data it appears that the majority of the males feel as though CUPHD has good overall quality of care, while females are a bit more critical. About 57% of the women perceive the quality of care to be good or excellent while 43% feel like the quality of care needs improvement or is poor. Do men not care too much about quality because few of them are actually in the health care setting? Does their level of education affect the way they perceive quality of care?

Question 4 asks: If an interpreter is needed to communicate with your provider, does your provider always have one available? Out of 11 males, 6 answered yes, 4 answered no, and 1 answered “not applicable”. Out of 45 females, 29 answered yes, 14 answered no and 2 answered “not applicable”. It seems as though more than half of the patients, female or male, experience having been able to deal with an interpreter if needed. During my time spent at CUPHD, interpreters are available on certain days than others. They seem to have an abundance of the Hispanic population on Tuesdays, while other days Hispanics were not seen as much. This could be the factor that influenced some patient’s decisions with question 4.

Based on the demographics table, more than 75% of males and females have received no less than a high school diploma. More than 60% of males and females are between the ages of 20-29 years. A little over 50% of males and females tend to stop education endeavors at the high school level. Latino patients seem to struggle with health insurance between the ages of 20-29. Other research questions that can derive from this data are whether or not there is a correlation between education level and likelihood to have insurance, and does education level provide placement in socioeconomic status?

More than 90% of the patients said that if their provider spoke the same language, the quality of care received would improve. The percentages infer that between males and females, a little over 40% of the patients perceive their quality of care to be “Good.” Spanish being the primary language for more than 95% of the patients, if the provider spoke the same language, then the perceived quality of care would be rated higher on the scale to excellence.

After analyzing the tables further, 60% of males and females claim that there is an interpreter available if needed, while 40% claim that there is not. Providers lack the initiative to provide interpreters on a frequent basis and this impacts the patient’s perceived quality of care. If an interpreter is not available, could the perceived quality of care by Hispanic patients still be excellent? Are providers not putting as much effort in providing quality care because the patient doesn’t understand English?

## CHAPTER 4: CONCLUSIONS

In relation to the questions provided in the questionnaire, there is a direct relationship between language proficiency and the perceived quality of care among the Hispanic population. Overall, the quality of care was generally good amongst males and females. 69% between both genders agree that care was good or excellent. For this specific clinic, interpreters were usually provided which influenced the Hispanic's perception of quality. Almost all patients answered that if their provider spoke the same language, the health care experience would be less difficult or confusing and have higher quality.

Through close examination of the surveys, it is not clear to determine whether education level was a determining factor in their decision of rating their quality of care. With most of the patients being between the ages of 20-29 years, it is safe to conclude that Hispanics in this age group struggle to acquire insurance because it is an age of transition from school, to occupation. In some cases, young adults are not fortunate enough to acquire a job right after school, if they complete school for that matter. With the economic downturn, chances of students graduating and acquiring jobs are very difficult, leaving young adults out of work *and* opportunity to gain health benefits. The findings in this research suggest that health care delivery to the Hispanic population in terms of quality care is limited due to a language barrier. Though quality of care is subjective, according to the

surveys, majority of the patients agree that quality of care would improve if the provider spoke the same language.



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